

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012	
NAME OF PROVIDER OR SUPPLIER BRAUN'S NURSING HOME LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710			
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/22/12</p> <p>Facility Number: 000437 Provider Number: 155520 AIM Number: 100273770</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Braun's Nursing Home LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with two separate basements was determined to be of Type V (000)</p>		K0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, both basements, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 80 and had a census of 60 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/27/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K0048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a complete written evacuation and fire safety plan addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2 for the protection of 60 of 60 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p>		K0048	<p>K048 The entire Fire Policy & Procedure statement is being reviewed and rewritten to address each concern. The following items will be modified or included in the statement: 1. Immediate responsibility of the staff discovering the fire to evacuate the area affected by the fire will be clearly outlined. 2. A clear overview of the various type of fire extinguishers located in the facility, to include the location and type of extinguishers. Also, a synopsis of the types of fire that each extinguisher is appropriate for. In regards to the dietary area, the policy and procedure will address the purpose of the overhead extinguishing system and the need to use the class K extinguisher. 3. The policy and procedure statement will be expanded to address ALL staffs response to an activated smoke detector in a resident's room. 4. The acronym RACE will be modified to reflect the proper verbiage "extinguish the fire with a fire extinguisher, or <u>EVACUATE</u> the area if the fire is too large for a fire extinguisher. 5. The acronym SWEEP will be included in the revised policy and procedure.</p>		04/13/2012	

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	<p>Based on a review of the facility's written fire safety plan in the Facility Disaster Plan on 03/22/12 at 11:50 a.m. with the Head of Maintenance present, the evacuation plan did not include information for the evacuation of the smoke compartment. Also, the fire safety plan did not address the use of the ABC type fire extinguishers located throughout the building or the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system, furthermore, the fire safety plan did not address staff reaction to a resident room battery operated smoke detector, if activated. Finally, the "E" in the R.A.C.E. acronym within the fire safety plan stated, "Extinguish the fire if small." Based on interview at the time of record review, the Head of Maintenance acknowledged the evacuation and fire safety plan was not a complete plan and would required staff to make the distinction between a large and small fire.</p> <p>3.1-19(b)</p>						

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K0051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire alarm control panels located in an area that was not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to</p>		K0051	<p>K051</p> <p>A hard wired smoke detector was installed by Tri-State Fire & Protection on March 30, 2012.</p>		03/30/2012	

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	<p>provide notification of a fire in that location. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 03/22/12 at 12:45 p.m. during a tour of the facility with the Head of Maintenance, the fire alarm control panel phone dialer was located in the Radio Room and was not electrically supervised by a smoke detector. This was acknowledged by the Head of Maintenance at the time of observation.</p> <p>3-1.19(b)</p>						

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K0052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on record review and interview, the facility failed to ensure documentation for the testing of 32 of 32 smoke detectors was correct. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's quarterly fire alarm system inspection reports in the Inspections book on 03/22/12 between 11:00 a.m. and 11:30 a.m. with the Head of Maintenance present, the four most recent quarterly fire alarm system inspection reports dated 04/27/11, 07/08/11, 9/13/11, and 12/19/11 all indicated on the</p>		K0052	<p>K052</p> <p>1.) The administration has instructed representatives of Tri-State Fire & Protection that ALL smoke detectors (total of 32) be tested at one time on an annual basis. During the inspection on March 30, 2012, each smoke detector was inspected and appropriate action was taken to assure that each smoke detector was in proper working order. The administration and maintenance supervisor will be responsible for overseeing the vendor's compliance with this requirement.</p> <p>2.) During the inspection conducted by Tri-State Fire & Protection on March 30, 2012, I spoke personally with Aaron Early regarding this oversight. He indicated that on 12/19/2011, the smoke detector did fail the test and he neglected to replace the smoke detector. In order to prevent this oversight in the</p>		03/30/2012	

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	<p>cover page the facility was provided with thirty two Photo type smoke detectors and zero Ion type smoke detectors, however, the most recent sensitivity test report dated 04/08/10 indicated nine of the thirty two smoke detectors were Ion type smoke detectors. During interview at the time of record review, the Head of Maintenance acknowledged the discrepancy in the type of smoke detectors listed on the quarterly fire alarm system inspection reports and the most recent sensitivity test report.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to provided written documentation 1 of 32 smoke detectors that failed the visual/functional test had been replaced. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect 24 residents, as well as staff and visitors in the 200 unit.</p>			<p>future, either the administrator, their designee or the maintenance supervisor will go over line item by line item on each report prior to signing and accepting the inspection. This will eliminate any failure of equipment and/or the need to replace deficient equipment from being overlooked in the future. Although the smoke detector in question passed the inspection on March 30th, it was replaced as a precaution and the notation is reflected in the inspection report on file.</p>			

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	<p>Findings include:</p> <p>Based on review of the facility's quarterly fire alarm system inspection reports in the Inspection book on 03/22/12 between 11:00 a.m. and 11:30 a.m. with the Head of Maintenance present, the 12/19/11 fire alarm system inspection report indicated eight of thirty two smoke detectors were tested visually and functionally. During this test one of the eight smoke detectors failed the visual/functional test. This smoke detector was located in the 200 unit corridor outside the sprinkler riser room. Furthermore, there was no documentation available to show the failed smoke detector was repaired or replaced. This was acknowledged by the Head of Maintenance at the time of record review.</p> <p>3.1-19(b)</p>						